FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041343

Facility Name: OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TERRACE

Address: 1300 Oak Ave. (Number) Evanston (City) 60201 (Zip Code)

County: Cook

Telephone Number: (847) 869-1300 **Fax #** (847) 869-1378

IDPA ID Number: 36-4041095

Date of Initial License for Current Owners: 1/1/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) Cary Buxbaum, CPA
(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TERRA# 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	4	Skilled (SNF)	4	1,464	1
2		Skilled Pediatric (SNF/PED)			2
3	53	Intermediate (ICF)	53	19,398	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	57	TOTALS	57	20,862	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	784		784	8
9	SNF/PED					9
10	ICF		11,062		11,062	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		11,846		11,846	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.78%

D. How many bed-hold days during this year were paid by Public Aid? N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERAT # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	89,359	12,309	7,200	108,868		108,868	(2,330)	106,538			1
2	Food Purchase		79,454		79,454	(5,355)	74,099	(795)	73,305			2
3	Housekeeping	19,137	4,005		23,142		23,142	123	23,265			3
4	Laundry	15,715	5,111		20,826		20,826		20,826			4
5	Heat and Other Utilities			34,983	34,983		34,983	422	35,405			5
6	Maintenance	27,785		38,053	65,838		65,838	(1,685)	64,153			6
7	Other (specify):*							1,036	1,036			7
8	**TOTAL General Services**	151,996	100,879	80,236	333,111	(5,355)	327,756	(3,229)	324,528			8
	B. Health Care and Programs											
9	Medical Director			300	300		300		300			9
10	Nursing and Medical Records	438,006	24,983	73,739	536,728		536,728	3,379	540,107			10
10a	Therapy			144	144		144		144			10a
11	Activities	23,285	4,525	1,728	29,538		29,538		29,538			11
12	Social Services			1,825	1,825		1,825		1,825			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							578	578			15
16	**TOTAL Health Care and Programs**	461,291	29,508	77,736	568,535		568,535	3,957	572,492			16
	C. General Administration											
17	Administrative	44,864			44,864		44,864	19,962	64,826			17
18	Directors Fees											18
19	Professional Services			33,712	33,712		33,712	(15,056)	18,656			19
20	Dues, Fees, Subscriptions & Promotions			23,308	23,308		23,308	(3,159)	20,149			20
21	Clerical & General Office Expenses	13,664	15,631	19,368	48,663		48,663	14,180	62,843			21
22	Employee Benefits & Payroll Taxes			80,022	80,022	5,355	85,377		85,377			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,736	1,736		1,736	143	1,879			24
25	Other Admin. Staff Transportation							600	600			25
26	Insurance-Prop.Liab.Malpractice			24,407	24,407		24,407	187	24,594			26
27	Other (specify):*							4,534	4,534			27
28	**TOTAL General Administration**	58,528	15,631	182,553	256,712	5,355	262,067	21,391	283,458			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	671,815	146,018	340,525	1,158,358		1,158,358	22,119	1,180,477			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TERRACE
0041343
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	5,355	
2	FOOD		5,355

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD#0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			36,896	36,896		36,896	65,422	102,318			30
31	Amortization of Pre-Op. & Org.			150	150		150		150			31
32	Interest			185,855	185,855		185,855	152,642	338,497			32
33	Real Estate Taxes			119,696	119,696		119,696	857	120,553			33
34	Rent-Facility & Grounds			171,000	171,000		171,000	(171,000)				34
35	Rent-Equipment & Vehicles			926	926		926	1,698	2,624			35
36	Other (specify):*			1,396	1,396		1,396	(1,396)				36
37	**TOTAL Ownership**			515,919	515,919		515,919	48,223	564,142			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			5,567	5,567		5,567		5,567			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,294	31,294		31,294		31,294			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			36,861	36,861		36,861		36,861			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	671,815	146,018	893,305	1,711,138		1,711,138	70,342	1,781,480			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC D # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,561	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(795)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,627)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,560)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,421)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	76,763		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 76,763		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 70,342		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TERRACE

ID# 0041343

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Jury Duty	(34)	10	2
3	LLC. Filling Fees	(600)	20	3
4	Trust Fees	(200)	20	4
5	Collections Fees	(206)	19	5
6	Capitalized R&M	(2,838)	6	6
7	Amortization Loan Fees - Facility	(1,396)	36	7
8	Amortization Loan Fees - Bldg Part.	(3,286)	36	8
9				9
10				10
11				11
12				12
13				13
14				14
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16				16
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82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(8,560)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBI # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary					(2,330)							(2,330)	1
2	Food Purchase	(795)											(795)	2
3	Housekeeping			123									123	3
4	Laundry													4
5	Heat and Other Utilities			167	255								422	5
6	Maintenance	(2,838)		103	1,203	(153)							(1,685)	6
7	Other (specify):*				137	899							1,036	7
8	**TOTAL General Services**	(3,633)		393	1,595	(1,584)							(3,229)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(34)			3,413								3,379	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				578								578	15
16	**TOTAL Health Care and Programs**	(34)			3,991								3,957	16
	C. General Administration													
17	Administrative			2,881	1,361	15,720							19,962	17
18	Directors Fees													18
19	Professional Services	(206)		(17,417)	419	2,148							(15,056)	19
20	Fees, Subscriptions & Promotions	(3,427)		74	194								(3,159)	20
21	Clerical & General Office Expenses			9,565	4,615								14,180	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			38	105								143	24
25	Other Admin. Staff Transportation			131	469								600	25
26	Insurance-Prop.Liab.Malpractice			84	103								187	26
27	Other (specify):*			1,503	865	2,166							4,534	27
28	**TOTAL General Administration**	(3,633)		(3,141)	8,131	20,034							21,391	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(7,300)		(2,748)	13,717	18,450							22,119	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DB # 0041343 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	5,561	58,282	614	965								65,422	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		151,830	240	572								152,642	32
33	Real Estate Taxes			310	547								857	33
34	Rent-Facility & Grounds		(171,000)										(171,000)	34
35	Rent-Equipment & Vehicles			530	1,168								1,698	35
36	Other (specify):*	(4,682)	3,286										(1,396)	36
37	**TOTAL Ownership**	879	42,398	1,694	3,252								48,223	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(6,421)	42,398	(1,054)	16,969	18,450							70,342	45

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD I# 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 171,000	Oakwood Care Real Estate LLC	100.00%	$	$ (171,000)	1
2	V	32	Interest Expense		Oakwood Care Real Estate LLC	100.00%	151,830	151,830	2
3	V	30	Depreciation		Oakwood Care Real Estate LLC	100.00%	58,282	58,282	3
4	V	36	Amortization		Oakwood Care Real Estate LLC	100.00%	3,286	3,286	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 171,000			$ 213,398	$ * 42,398	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TER # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 123	$ 123	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	167	167	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	103	103	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	2,881	2,881	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	383	383	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	74	74	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	9,565	9,565	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	38	38	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	131	131	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	84	84	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	1,503	1,503	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	614	614	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	240	240	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	310	310	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	530	530	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	17,800	PREFERRED BOOKKEEPING	100.00%		(17,800)	32
33	V	19	COMPUTER	0	PREFERRED BOOKKEEPING	100.00%	0		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 17,800			$ 16,746	$ * (1,054)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TER # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 255	$ 255	15
16	V	6	REPAIRS AND MAINT.	0	S.I.R. MANAGEMENT, INC.	100.00%	1,203	1,203	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	137	137	17
18	V	10	NURSING	0	S.I.R. MANAGEMENT, INC.	100.00%	3,413	3,413	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	578	578	19
20	V	17	ADMINISTRATIVE	0	S.I.R. MANAGEMENT, INC.	100.00%	1,361	1,361	20
21	V	19	PROFESSIONAL FEES	0	S.I.R. MANAGEMENT, INC.	100.00%	419	419	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	194	194	22
23	V	21	CLERICAL & GENERAL	0	S.I.R. MANAGEMENT, INC.	100.00%	4,615	4,615	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	105	105	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	469	469	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	103	103	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	865	865	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	965	965	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	572	572	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	547	547	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	1,168	1,168	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 16,969	$ * 16,969	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TER # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 0	S.I.R. MANAGEMENT, INC.	100.00%	$ 985	$ 985	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	166	166	16
17	V	17	ADMIN./LEGAL SALARIES	0	S.I.R. MANAGEMENT, INC.	100.00%	15,720	15,720	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	2,148	2,148	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	2,166	2,166	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB	0	S.I.R. MANAGEMENT, INC.	100.00%	0		22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	0		23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	504	S.I.R. MANAGEMENT, INC.	100.00%	351	(153)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	61	61	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	7,200	S.I.R. MANAGEMENT, INC.	100.00%	3,885	(3,315)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	672	672	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,704			$ 26,154	$ * 18,450	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TER # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 23,581	$ 23,581	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	23,581	CCS EMPLOYEE BENEFIT GROUP	100.00%		(23,581)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 23,581			$ 23,581	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TER # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TER # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TER # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TER # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TER # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERA # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Tom Winter	Member	Administrative	3.51%	See Attached	1.22	0.02	Alloc Sal Pref	$ 2,881	17-7	1
2	Arturo Rominquit	Relative	Clerical	0.00	See Attached	0.81	0.02	Alloc Sal Pref	443	21-7	2
3	Bryan Barrish	Member	Administrative	31.00%	See Attached	0.85	0.02	Alloc Sal. Sir	4,969	17-7	3
4	Mike Giannini	Member	Administrative	15.50%	See Attached	0.76	0.02	Alloc Sal. Sir	2,968	17-7	4
5	Louise Bergthold	Member	Administrative	3.51%	See Attached	1.04	0.02	Alloc Sal. Sir	3,214	1-7	5
6	Nenita Guzman	Relative	Administrative	0.00	See Attached	1.04	0.02	Alloc Sal. Sir	985	17-7	6
7	Eric Rothner	Relative	Administrative	0.00	See Attached	0.12	0.02	Alloc Sal. Sir	1,265	17-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 16,725		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC I # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC I # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	Book. /Accnt. Income	878,492	11	$ 6,088	$	17,800	$ 123	1
2	5	UTILITIES	Book. /Accnt. Income	878,492	11	8,220		17,800	167	2
3	6	REPAIRS AND MAINT.	Book. /Accnt. Income	878,492	11	5,069		17,800	103	3
4	17	ADMIN. FINANCIAL SAL.	Book. /Accnt. Income	878,492	11	142,165	142,165	17,800	2,881	4
5	19	PROFESSIONAL FEES	Book. /Accnt. Income	878,492	11	18,910		17,800	383	5
6	20	DUES,SUBSCRIPTIONS	Book. /Accnt. Income	878,492	11	3,657		17,800	74	6
7	21	CLERICAL	Book. /Accnt. Income	878,492	11	472,061	403,426	17,800	9,565	7
8	24	SEMINARS	Book. /Accnt. Income	878,492	11	1,858		17,800	38	8
9	25	ADMIN. STAFF TRAVEL	Book. /Accnt. Income	878,492	11	6,465		17,800	131	9
10	26	INSURANCE	Book. /Accnt. Income	878,492	11	4,146		17,800	84	10
11	27	EMPLOYEE BENEFITS	Book. /Accnt. Income	878,492	11	74,163		17,800	1,503	11
12	30	DEPRECIATION	Book. /Accnt. Income	878,492	11	30,298		17,800	614	12
13	32	INTEREST	Book. /Accnt. Income	878,492	11	11,823		17,800	240	13
14	33	REAL ESTATE TAXES	Book. /Accnt. Income	878,492	11	15,297		17,800	310	14
15	35	EQUIPMENT RENTAL	Book. /Accnt. Income	878,492	11	26,147		17,800	530	15
16										16
17										17
18										18
19	19	COMPUTER	Direct Allocation							19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 826,367	$ 545,591		$ 16,746	25

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC I # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	642,911	10	$ 13,508	$	12,154	$ 255	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	642,911	10	63,644	42,834	12,154	1,203	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	642,911	10	7,250		12,154	137	3
4	10	NURSING	PATIENT DAYS	642,911	10	180,529	180,529	12,154	3,413	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	642,911	10	30,553		12,154	578	5
6	17	ADMINISTRATIVE	PATIENT DAYS	642,911	10	71,994	71,994	12,154	1,361	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	642,911	10	22,153		12,154	419	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	642,911	10	10,256		12,154	194	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	642,911	10	244,124	177,193	12,154	4,615	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	642,911	10	5,556		12,154	105	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	642,911	10	24,821		12,154	469	11
12	26	INSURANCE	PATIENT DAYS	642,911	10	5,468		12,154	103	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	642,911	10	45,778		12,154	865	13
14	30	DEPRECIATION	PATIENT DAYS	642,911	10	51,045		12,154	965	14
15	32	INTEREST	PATIENT DAYS	642,911	10	30,234		12,154	572	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	642,911	10	28,948		12,154	547	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	642,911	10	61,803		12,154	1,168	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 897,664	$ 472,550		$ 16,969	25

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC I # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	642,911	10	$ 52,122	$ 52,122	12,154	$ 985	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	642,911	10	8,770		12,154	166	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	642,911	10	831,558	831,558	12,154	15,720	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	642,911	10	113,620		12,154	2,148	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	642,911	10	$ 114,558	$	12,154	$ 2,166	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	56,277	56,277			8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 9,470	$		$	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	237,604	10	165,366	165,366	504	351	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	237,604	10	$ 28,790	$	504	$ 61	13
14										14
15										15
16	1	DIETICIAN SALARIES	Dietician Service Inc.	125,400	10	67,672	67,672	7,200	3,885	16
17	7	EMP. BEN.-GEN. ADMIN.	Dietician Service Inc.	125,400	10	11,698		7,200	672	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,459,901	$ 1,172,995		$ 26,154	25

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC I # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	Direct Allocation			$	$		$ 23,581	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 23,581	25

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC I # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC I # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC I # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC I # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC I # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERA' # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	CIB Bank - RO		X	Mortgage	$14,243.67	8/25/99	$ 1,744,600	$ 1,736,294		8.5000	$ 151,830	1
2												2
3	CIB Bank		X	Improvements				837,054			54,464	3
4	CIB Bank		X	Mortgage				692,089			60,752	4
5												5
	Working Capital											
6	CIB Bank/S.I.R. Line		X	Working Capital	$3,520.25			920,000			49,058	6
7	Shareholders	X		Working Capital		1/1/96	300,000	270,000			20,919	7
8	First Premium Services, Inc.		X	Insurance Premiums							662	8
9	TOTAL Facility Related				$17,763.92		$ 2,044,600	$ 4,455,437			$ 337,685	9
	B. Non-Facility Related*											
10	Supplemental Schedule							3,418			812	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 3,418			$ 812	14
15	TOTALS (line 9+line14)						$ 2,044,600	$ 4,458,855			$ 338,497	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATI # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Due to Others		X	Various			$	$ 3,418			$	1
2												2
3	Alloc. Preferred Bookkeeping	X									240	3
4												4
5	Alloc. S.I.R. Mgmt Inc.	X									572	5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 3,418			$ 812	21

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOO # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	117,900	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	117,853	2
3. Under or (over) accrual (line 2 minus line 1).	$	(47)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	120,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	120,553	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	112,810	8
	1996	113,044	9
	1997		10
	1998		11
	1999	116,996	12

Accrual = 116,996 X 1.03 = 120,600

Alloc. Pref. Book. $310 + Alloc. SIR Mgmt, Inc $547

Alloc. Total = $857 incl. Above on ln 2.

Cost Reports not filed since 1996

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TER # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,609 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 1,198 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 240 4. Dates Incurred: 01/01/96

Nature of Costs: Organization Costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1996	$ 150,000	1
2					2
3	TOTALS			$ 150,000	3

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	57			1996	$ 1,757,500	$ 44,895	35	$ 50,214	$ 5,319	$ 259,078	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PAINT FACILITY			1996	10,000	256	20	500	244	2,083	9
10	EXHAUST FANS			1996	2,650	290	20	100	(157)	1,061	10
11	PAINT FACILITY			1996	23,000	590	20	1,150	560	4,696	11
12	GARAGE ENTRANCE			1996	5,330	137	20	267	130	1,112	12
13	PAINT FACILITY			1996	15,000	385	20	750	365	3,188	13
14	AIR CONDITIONERS			1996	6,128	697	20	306	(391)	1,402	14
15	NURSE CALL SYSTEM			1996	10,279	1,169	20	514	(655)	2,399	15
16	ROOF WORK			1996	17,980	461	20	899	438	4,345	16
17	PHASE I ENVIRONMENTA			1996	1,950	50	20	98	48	490	17
18	SIGNS/LIGHT FIXTURES			1996	4,050		20	203	203	811	18
19	HALLWAY RAILINGS			1996	4,200	460	20	210	(250)	1,505	19
20	NEW BATHROOM			1996	1,138	129	20	57	(72)	266	20
21	FLOORING			1997	26,918	690	20	1,346	656	4,935	21
22	FLOORING			1997	3,592	92	20	180	88	660	22
23	FLOORING			1997	16,876	433	20	844	411	3,306	23
24	PAGE 12-2 REP TOTALS				8,751	369		327	(42)	2,110	24
25	PAGE 12-1 REP TOTALS				7,261	292		297	5	1,376	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35	PAGE 12A TOTALS				1,062,705	5,361		7,124	1,763	14,329	35
36	TOTAL (lines 4 thru 35)				$ 2,985,308	$ 56,756		$ 65,386	$ 8,663	$ 309,152	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PORCH CARPETING			1997	2,732	70	20	137	67	491	9
10	HANDRAILS			1997	6,984	804	20	349	(455)	1,222	10
11	PHONE SYSTEM			1997	4,631	534	20	232	(302)	812	11
12	AWNING CANOPY			1997	2,230	57	20	112	55	392	12
13	IRON FENCE			1997	1,050	81	20	53	(28)	186	13
14	PAINT FACILITY			1997	2,631	67	20	132	65	484	14
15	BEAUTY SALON REMODEL			1997	829	21	20	41	20	150	15
16	FLOORS & WALLS			1997	4,630	119	20	232	113	831	16
17	FIRE DOORS			1997	672	77	20	34	(43)	218	17
18	SIGN			1997	2,070	238	20	104	(134)	587	18
19	FRONT DOOR			1997	575	66	20	29	(37)	164	19
20	WATER HEATER			1997	4,625	533	20	231	(302)	1,234	20
21	WIRING/ALARM			1997	5,543	142	20	277	135	1,062	21
22	FLOORING			1997	1,576	40	20	79	39	257	22
23	ELECTRICAL WORK			1998	4,221	108	20	211	103	510	23
24	ROOM SIGNS			1998	948	182	20	47	(135)	237	24
25	SEWER WORK			1998	3,100	79	20	155	76	400	25
26	FLOORING CARPET			1998	3,400	653	20	170	(483)	482	26
27	SEWER WORK			1999	3,800	97	20	190	93	301	27
28	WIRING			2000	2,838		20	83	83	83	28
29	ARCHITECT FEES			2000	64,260	69	20	268	199	268	29
30	CARPETING			2000	3,801	190	20	48	(142)	48	30
31	PHONE SYSTEM			2000	2,745	137	20	23	(114)	23	31
32	STOWELL CONSTR			2000	930,164	994	20	3,876	2,882	3,876	32
33	SPRINKLER			2000	2,650	3	20	11	8	11	33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,062,705	$ 5,361		$ 7,124	$ 1,763	$ 14,329	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5			1993	Alloc. S.I.R	2,861	91	35	82	(9)	613	5
6				Properties							6
7											7
8											8
	Improvement Type**										
9	Alloc. Preferred Bookkeeping			1997	3,573	135	20	179	44	680	9
10	Alloc. Preferred Bookkeeping			1999	28	9	20	1	(8)	2	10
11	Alloc. Preferred Bookkeeping			2000	179		20	4	4	4	11
12											12
13											13
14	Alloc. S.I.R. Properties - Preferred Bookkeeping			1993	46	2	20	2		17	14
15	Alloc. S.I.R. Properties - Preferred Bookkeeping			1994	27	1	20	1		9	15
16	Alloc. S.I.R. Properties - Preferred Bookkeeping			1997	11	1	20	1		2	16
17	Alloc. S.I.R. Properties - Preferred Bookkeeping			1998	173	17	20	9	(8)	22	17
18	Alloc. S.I.R. Properties - Preferred Bookkeeping			1999	363	36	20	18	(18)	27	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 7,261	$ 292		$ 297	$ 5	$ 1,376	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5			1993	Alloc.S.I.R.	5,051	160	35	144	(16)	1,082	5
6				Prop. Mgmt							6
7											7
8											8
	Improvement Type**										
9											9
10	Alloc. S.I.R. Properties - S.I.R. Management			1993	82	4	20	4		31	10
11	Alloc. S.I.R. Properties - S.I.R. Management			1994	48	1	20	2	1	16	11
12	Alloc. S.I.R. Properties - S.I.R. Management			1997	19	2	20	1	(1)	4	12
13	Alloc. S.I.R. Properties - S.I.R. Management			1998	306	31	20	15	(16)	38	13
14	Alloc. S.I.R. Properties - S.I.R. Management			1999	640	64	20	32	(32)	48	14
15											15
16											16
17	Alloc. S.I.R. Management, Inc.			1993	2,170	72	20	109	37	855	17
18	Alloc. S.I.R. Management, Inc.			1994	7		20	1	1	4	18
19	Alloc. S.I.R. Management, Inc.			1995	50	3	20	2	(1)	13	19
20	Alloc. S.I.R. Management, Inc.			1999	236	16	20	12	(4)	14	20
21	Alloc. S.I.R. Management, Inc.			2000	142	16	20	5	(11)	5	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 8,751	$ 369		$ 327	$ (42)	$ 2,110	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATIN(# 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 367,307	$ 39,346	$ 36,702	$ (2,644)		$ 162,770	37
38	Current Year Purchases	8,587	688	230	(458)		230	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 375,894	$ 40,034	$ 36,932	$ (3,102)		$ 163,000	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,511,202	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 96,790	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 102,318	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 5,561	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 472,152	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TERRACE
0041343
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
Oakwood Care Associates Operating LLC (Facility)	205,993	25,105	20,601	(4,504)	80,641
Oakwood Care Real Estate LLC (Bldg Partnership)	150,000	13,387	15,000	1,613	75,000
Preferred Bookkeeping - Office Equipment	1,830	128	173	45	1,057
Preferred Bookkeeping - Computer	2,321	169	212	43	1,489
S.I.R.Properties - Preferred Bookkeeping	3				2
S.I.R. Properties - S.I.R. Management	5				4
S.I.R. Management, Inc.	7,155	557	716	159	4,577
TOTALS	367,307	39,346	36,702	(2,644)	162,770

LINE 29: CURRENT YEAR

Oakwood Care Associates Operating LLC (Facility)	8,242	625	209	(416)	209
Oakwood Care Real Estate LLC (Bldg Partnership)					
Preferred Bookkeeping - Office Equipment					
Preferred Bookkeeping - Computer	121	24	10	(14)	10
S.I.R.Properties - Preferred Bookkeeping					
S.I.R. Properties - S.I.R. Management					
S.I.R. Management, Inc.	224	39	11	(28)	11
TOTALS	8,587	688	230	(458)	230

LINE 30: FULLY DEPRECIATED

Oakwood Care Associates Operating LLC (Facility)					
Oakwood Care Real Estate LLC (Bldg Partnership)					
Preferred Bookkeeping - Office Equipment					
Preferred Bookkeeping - Computer					
S.I.R.Properties - Preferred Bookkeeping					
S.I.R. Properties - S.I.R. Management					
S.I.R. Management, Inc.					
TOTALS					

TOTALS (Should Tie to Totals on Page 13)

Oakwood Care Associates Operating LLC (Facility)	214,235	25,730	20,810	(4,920)	80,850
Oakwood Care Real Estate LLC (Bldg Partnership)	150,000	13,387	15,000	1,613	75,000
Preferred Bookkeeping - Office Equipment	1,830	128	173	45	1,057
Preferred Bookkeeping - Computer	2,442	193	222	29	1,499
S.I.R.Properties - Preferred Bookkeeping	3				2
S.I.R. Properties - S.I.R. Management	5				4
S.I.R. Management, Inc.	7,379	596	727	131	4,588
TOTALS	375,894	40,034	36,932	(3,102)	163,000

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DB# 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 926 Description: Copier - Toshiba: $926
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOD TER# 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWO# 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOO # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DB # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 94,556	$ 105,417	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	36,649	36,649	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,738	1,738	6
7	Other Prepaid Expenses	7,852	7,852	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 140,795	$ 151,656	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		150,000	13
14	Buildings, at Historical Cost		1,757,500	14
15	Leasehold Improvements, at Historical Cos	1,150,063	1,150,063	15
16	Equipment, at Historical Cost	269,080	419,080	16
17	Accumulated Depreciation (book methods)	(233,973)	(580,695)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	4,587	4,587	22
23	Other(specify): See supplemental schedule		11,502	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,189,757	$ 2,912,037	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,330,552	$ 3,063,693	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 113,767	$ 113,767	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,206,618	1,206,618	29
30	Accrued Salaries Payable	43,933	43,933	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,279	2,279	31
32	Accrued Real Estate Taxes(Sch.IX-B)	120,600	120,600	32
33	Accrued Interest Payable	10,348	16,907	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,497,545	$ 1,504,104	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,515,943	1,515,943	39
40	Mortgage Payable		1,736,294	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,515,943	$ 3,252,237	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,013,488	$ 4,756,341	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,682,936)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,330,552	$ #REF!	48

*(See instructions.)

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC 1# 0041343 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
Construction In Progress					
Loan Costs - Net		11,502			
		11,502			

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKW# 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,214,732)	1	
2	Restatements (describe):		2	
3	**Schedule attached**		3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,214,732)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(468,204)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (468,204)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,682,936)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number	OAKWOOD CARE ASSOCIATES OF #	0041343	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(1,214,732)
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		(1,214,732)
Equity(Deficit) from Page 17 Col 1		(1,682,936)
Related Party		
Equity(Deficit)	32686	
Income	-42398	
		(9,712)
Combined Equity - End of Year		(1,692,648)

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,195,741	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,195,741	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,355	12
13	Barber and Beauty Care	6,600	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	35,809	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 46,764	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	395	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 395	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	34	27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 34	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,242,934	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	333,111	31
32	Health Care	568,535	32
33	General Administration	256,712	33
	B. Capital Expense		
34	Ownership	515,919	34
	C. Ancillary Expense		
35	Special Cost Centers	5,567	35
36	Provider Participation Fee	31,294	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,711,138	40
41	**Income before Income Taxes (line 30 minus line 40)****	(468,204)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (468,204)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No-Sch Attac If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number OAKWOOD CARE ASSOCIATES (# 0041343 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2	Jury Duty - Adjust out on p. 5.	34
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	34

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBI # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,032	2,080	$ 47,915	$ 23.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,733	9,389	188,594	20.09	3
4	Licensed Practical Nurses	2,882	3,079	48,815	15.85	4
5	Nurse Aides & Orderlies	18,839	19,892	152,682	7.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,032	2,080	23,285	11.19	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,048	2,080	26,671	12.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,302	8,892	62,688	7.05	15
16	Dishwashers					16
17	Maintenance Workers	2,024	2,080	27,785	13.36	17
18	Housekeepers	3,376	3,504	19,137	5.46	18
19	Laundry	2,834	2,950	15,715	5.33	19
20	Administrator	2,024	2,080	44,864	21.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,622	1,842	13,664	7.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	71,748	59,948	$ 671,815 *	$ 11.21	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	288	$ 7,200	1-3	35
36	Medical Director	Monthly	300	9-3	36
37	Medical Records Consultant	161	4,032	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	900	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	6	144	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,728	11-3	44
45	Social Service Consultant	37	1,825	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	528	$ 16,129		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,677	$ 32,968	10-3	50
51	Licensed Practical Nurses	454	8,817	10-3	51
52	Nurse Aides	1,363	27,022	10-3	52
53	TOTAL (lines 50 - 52)	3,494	$ 68,807		53

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC DBD OAKWOOI # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOHN STARE	Administrator	0%	$ 44,864
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 44,864

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PREFERRED BOOKKEPING	ACCOUNTING	$ 10,600
FR&R	ACCOUNTING	4,250
SCHWARTZ & FREEMAN	LEGAL	8,260
PERSONNEL PLANNERS	UNEMPLOYMENT CSLT	434
DPSI	COMPUTER SERVICES	1,731
MID AMERICA PROGRAMMING	MDS SOFTWARE	1,237
PREFERRED BOOKKEPING	BOOKKEEPING	7,200
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 33,712

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 5,799
Unemployment Compensation Insurance	4,767
FICA Taxes	50,538
Employee Health Insurance	16,682
Employee Meals	5,355
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS	2,236
TOTAL (agree to Schedule V, line 22, col.8)	$ 85,377

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	15,371
Health Care Worker Background Check	60
(Indicate # of checks performed 6)	
LICENSES & PERMITS	4,250
ADVERTISING & PROMOTION	2,627
Alloc. Pref.Book. + Sir Mgmt Inc.	268
Less: Public Relations Expense	(2,627)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,149

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,736
Alloc. Pref.Book. + Sir Mgmt Inc.	143
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,879

**See instructions.

Facility Name & ID Number OAKWOOD CARE ASSOCIATES OPERATING LLC D # 0041343 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **13,002** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **N/A** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? **No** YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **31,293**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **5,355** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **No**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw